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**Developing a National Family Planning/
Reproductive Health Clinical Training System
in Kenya**

JHP-02

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ABBREVIATIONS AND ACRONYMS

AIDS	Acquired immune deficiency syndrome
APHIA	AIDS, Population and Health Integrated Assistance
APMS ^o	Automated Program Monitoring System developed by JHPIEGO
ATS	Advanced training skills
AVSC	AVSC International
CAI	Cooperative Agreement Indicator
COPE	Client-oriented, provider-efficient
CPG	Clinical Placement Guide
CS	Child survival
CTS	Clinical training skills
CTU	Contraceptive technology update
DFID	Department for International Development
DMP	Division of Manpower and Planning
DON	Division of Nursing
DPHC	Division of Primary Health Care, formerly the Division of Family Health (DFH)
DTC	Decentralized Training Center
DTT	District training team
ECHN	Enrolled Community Health Nurse
FHI	Family Health International
FP	Family planning
HIV	Human immunodeficiency virus
IP	Infection prevention
IR	Intermediate result
IUD	Intrauterine device
KEPI	Kenya Expanded Program of Immunizations
KRCHN	Kenya Registered Community Health Nurse
LQAS	Lot Quality Assurance Sampling
M&E	Monitoring and evaluation
MEDEX	A federally funded group affiliated with the University of Hawaii School of Medicine that works to improve health services in underserved populations
ML/LA	Minilaparotomy under local anesthesia
MOH	Ministry of Health



MTC	Medical Training College
MVA	Manual vacuum aspiration
NASCOP	Kenya National AIDS/STDs Control Programme
NCK	Nursing Council of Kenya
NGO	Nongovernmental organization
OJT	On-the-job training
PAC	Postabortion care
ProTrain®	Training projection model developed by The Futures Group International and JHPIEGO
QMS	Quality monitoring system
RETAG	Reproductive Health Technical Advisory Group
RH	Reproductive health
RHSA	Reproductive Health Sector Assessment
SDG	Service delivery guidelines
SDP	Service delivery point
SO	Strategic objective
SR	Sub-result
STI	Sexually transmitted infection
TALC	Technology-assisted learning center
TIMS®	Training Information Monitoring System developed by JHPIEGO
TIS	Training information system
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
ZNFPC	Zimbabwe National Family Planning Council



EXECUTIVE SUMMARY

Under the USAID AIDS, Population and Health Integrated Assistance project, JHPIEGO has been working since 1995 with the Division of Primary Health Care (DPHC), the Nursing Council of Kenya (NCK) and the Division of Nursing (DON) to pioneer the development of an integrated clinical training system used for both preservice and inservice family planning (FP) training. JHPIEGO and its partners have strengthened both inservice training and preservice education systems cost-effectively by developing a core group of trainers, tutors and preceptors. In addition, training materials, for both student and participant use, have been supplied to a limited number of clinical facilities.

Training in both the inservice and preservice nursing wings has been linked at the clinical training site. Using one group of trainers for a variety of training needs results in economies of scale. The key training institutions are defining the mix of skills appropriate for preservice nursing programs and determining which skills should continue to be met through inservice training. Training has been decentralized from the national-level DPHC to the decentralized training centers (DTCs) so that more FP training is conducted each year. Training costs for inservice FP courses have been reduced dramatically—and will continue to be reduced as the preservice nursing program is able to absorb more FP and reproductive health (RH) interventions. In support of this integrated system, JHPIEGO, the DPHC, NCK and DON have developed quality training materials, including a self-directed learning package for students and a *National FP/RH Resource Manual*. This *Resource Manual* is the first reference manual in Kenya developed for use in both preservice education and inservice training. JHPIEGO and the DPHC have also provided technical assistance and training to ensure that trainers have standardized clinical and training skills in infection prevention (IP), FP counseling and IUD insertion.

JHPIEGO is assisting the Ministry of Health to decentralize clinical and training expertise from the DPHC to the DTCs. At each DTC, one trainer has been selected to attend a central-level course in a specific technical area. Following the course, the DTC trainers cotrain this course with a DPHC or JHPIEGO trainer. DPHC trainers continue to cotrain and “cosupervise” with the DTC trainers until they are proficient in both the technical content and training skills. Using this strategy, 13 DTCs have provided courses in IP, FP counseling, contraceptive technology and clinical training skills for all staff or faculty involved in training either nursing students or inservice participants. The DPHC and JHPIEGO are assisting the NCK and DON to establish a formal system of “preceptorship” that will help ensure that clinical trainers, once trained, will only be deployed to health services where they will be able to use their clinical training skills. The DPHC and JHPIEGO are also promoting a system in which nursing tutors, DTC trainers and clinical preceptors meet regularly to discuss student scheduling in the clinical area, student progress toward training objectives and other clinical training needs.

The IUD structured on-the-job training (OJT) program, the first of its kind in Kenya, is making quality clinical FP training sustainable at the facility level. The 15 hospitals/health centers where the IUD OJT program has been started are now independent of the 6-week basic FP course for training qualified FP service providers. Graduates from the OJT program have moved on to become OJT trainers. Thus, structured OJT offers not only a sustainable approach to training service providers, it also offers the possibility of site-based sustainable training for clinical preceptors.

JHPIEGO has also developed a computer-based Training Information Monitoring System (TIMS[®]) that helps ensure that the most appropriate trainer/tutor candidate is being trained at each site.



JHPIEGO is working with other Cooperating Agencies and the Division of Manpower and Planning (DMP) to institute a national training information system that will plan for meeting training needs and will track training in all technical areas to provide the DMP with accurate, timely data on national training.

In summary, this project has made substantial gains in meeting sub-result 3.3, *Key FP and HIV/AIDS service delivery support systems strengthened and institutionalized*, in USAID/Kenya's Office of Population and Health Results Framework. It has been successful in assisting the MOH to establish a national FP training system, which has now begun the project's consolidation phase, with the key components of inservice training and preservice education programs for nurses in place and functioning at a basic level. This consolidation phase is also the preparatory phase for moving next year into an expansion phase. This new phase will expand the preservice nursing program to cover the rest of Kenya's nursing schools and will move both inservice training and preservice education from an FP focus to an RH focus.



Developing a National Family Planning/Reproductive Health Clinical Training System in Kenya

INTRODUCTION

The USAID/Kenya AIDS, Population and Health Integrated Assistance (APHIA) project mid-term review stimulated this examination of the JHPIEGO/Kenya program interventions to strengthen family planning/reproductive health (FP/RH) training system capacity. In recent years, JHPIEGO efforts have focused on developing training capacity and institutionalizing the training support begun with the Division of Primary Health Care (DPHC, formerly the Division of Family Health [DFH]) in 1992 as well as enhancing opportunities for sustainability, where possible.

Prior to 1995, JHPIEGO worked primarily with the University of Nairobi Faculty of Medicine, Department of Obstetrics and Gynecology (Department of Ob/Gyn), to strengthen FP and RH skills of medical interns and medical students. Through institutionalization of curricular changes, the Department of Ob/Gyn and JHPIEGO succeeded in ensuring that medical doctors graduate with basic FP skills.¹ Although funding to the Department of Ob/Gyn ended in 1996, medical students and interns continue to be trained in ML/LA, manual vacuum aspiration (MVA), IUD insertion and several other basic FP skills, at no cost to USAID.

When USAID funding for Kenya was severely reduced in 1995, JHPIEGO and USAID/Nairobi decided that, because the medical program was adequately institutionalized to continue without further USAID funding, they would shift their focus to inservice training and preservice nursing education. Although effective (see Valadez et al 1997), the inservice FP training program was too expensive to be sustained without donor funding. USAID/JHPIEGO was spending almost US\$1 million annually to train service providers, half of whom—because of deployment or retirement—did not end up providing FP services. With consultation from the DPHC, the Division of Nursing (DON) and the Nursing Council of Kenya (NCK), JHPIEGO shifted from a strategy focused primarily on inservice training to one that promoted a more balanced preservice/inservice mix.

The JHPIEGO/Kenya program was implemented in three phases: assessment, development and consolidation. In the mid-1990s, JHPIEGO focused on the assessment phase. During this phase, JHPIEGO determined which clinical skills nurses were lacking, and what infrastructure support needed upgrading to ensure appropriate and adequate training. (This phase began in 1995.) In the development phase (January 1997 to December 1998), JHPIEGO focused on developing sustainable training programs in both the preservice and inservice sectors. This phase was accomplished by building the human and material infrastructure necessary for clinical training for both preservice education and inservice training at key sites. Finally, during the consolidation phase from January 1999 to September 2000, JHPIEGO will provide financial and technical support to these institutions to help them consolidate the training system. During this phase, JHPIEGO and the DPHC will use the gains made in FP training to prepare for a new expansion phase in which the decentralized training centers (DTCs) will expand to additional nursing schools and move from an FP focus to an RH focus.

¹ For example, the Dental and Medical Practitioners Board now requires that all interns conduct 10 minilaparotomies under local anesthesia (ML/LA) prior to medical registration.



BACKGROUND

The DPHC began inservice FP training in 1972. In 1990, USAID, the major funding agency for these activities, commissioned an evaluation (Ministry of Health/Division of Family Health 1990) "to document the quantity and quality of the training which has already been accomplished and to make recommendations for future activities." This evaluation identified several areas that required strengthening and revision including:

- ◆ Inadequate facilities at the DTCs
- ◆ The lack of a standardized training approach
- ◆ The inability of the DPHC to make long-range manpower projections
- ◆ The trainers' need for updated training skills
- ◆ The lack of a training-of-trainers curriculum for instructing new clinical trainers
- ◆ The lack of specialized job responsibilities among DPHC staff (which contributed to a lack of technical and administrative expertise)

Following this evaluation, USAID requested that JHPIEGO assist the DPHC to review and revise the inservice FP curriculum and provide overall financial support and technical assistance to the project. The initiative emphasized training adequate numbers of service providers. In addition, the initiative stressed developing the organizational and training skills of DPHC training unit staff and DTC trainers so that they could manage inservice training without technical assistance.

JHPIEGO's focus with the DPHC training unit has been to help them transform from a unit that primarily conducts RH training to a body that sets clinical and programmatic standards, develops curricula, ensures that trainers have standardized clinical skills, and monitors the quality of clinical training. Prior to JHPIEGO support, DPHC trainers had no special clinical skills; therefore, technical assistance for infection prevention (IP), FP counseling and method provision frequently had to be provided through expatriate technical assistance. DPHC trainers were given the opportunity to excel in select technical areas. And, the program has provided them with the chance to receive special training inside or outside of Kenya, and then to be mentored by training with master trainers in their area of expertise. To date, JHPIEGO has helped the DPHC to develop advanced trainers² who are clinical experts in IP, counseling, contraceptive technology and clinical training skills. Some of these advanced trainers provide technical assistance to other JHPIEGO programs in the East and Southern Africa region.

Prior to JHPIEGO involvement with the Kenya FP training program, the 8-week FP course was taught almost exclusively by 14 DPHC inservice trainers. The basic inservice training course assumed that participants had no prior FP/RH knowledge or experience, and it was not effectively targeted to train FP service providers. Deployment was a major training issue; approximately twice the number of nurses were being trained in this course than were needed to meet service delivery demand.³ At approximately US\$2,000 per participant, the cost of inservice training was clearly unsupported by the government. The inordinate cost of Kenya's inservice training was vividly demonstrated in the early 1990s. When USAID stopped funding the training program for two years, all FP training stopped.

² See **Appendix A** for definitions for levels of trainers in the JHPIEGO Trainer Development Pathway.

³ After being trained, half of all course participants were not working in a unit where they could apply their FP skills.

From 1992 to 1994 the DPHC, with JHPIEGO assistance, reviewed and revised the inservice training curriculum to address many of the issues raised in the 1990 USAID evaluation. Training was refocused to a competency-based methodology and interactive training approaches were integrated into all training. Following this revision, training activities began in 1994 with two Training-of-Trainers and two IUD Standardization/Clinical Preceptor Skills workshops conducted for the DPHC and DTC trainers.

Since 1992 when JHPIEGO began supporting the training program, the emphasis of the DPHC has gradually moved from providing direct training to supporting 13 provincial training teams (at the DTCs). With JHPIEGO assistance, the DPHC revised the 8-week basic FP course to a 6-week schedule. An 8-day dispensary-level FP course was developed for nurses who were providing nonclinical methods or supervising community-based distributors. JHPIEGO worked with the DPHC and the clinical sites to designate "clinical preceptors"—service providers whose duties also included clinical training—and then to standardize their service delivery and training skills in IP, counseling, contraceptive methods and training skills. A structured on-the-job training (OJT) course in IUD skills was developed for nurses who had practical or theoretical knowledge/skills in nonclinical methods and who needed only IUD skills to be able to provide a full range of FP methods.⁴

JHPIEGO assistance has also helped to redefine the national training strategy. Prior to 1996, the DPHC provided technical assistance and training only for practicing service providers. Little effort was made to understand why newly graduated nurses were unable to perform basic FP/RH skills correctly. The reaction to inadequate preservice education was simply to retrain FP service providers during the 6-week basic FP inservice course. The NCK and the DON felt that nursing school graduates were competent in FP counseling and method provision upon graduation, and should, therefore, be allowed to provide FP services immediately upon graduation. Clinical observation, however, provided empiric evidence that this was not the case. The DPHC, which is responsible for certifying nurses as competent in basic FP skills, was unwilling to allow new graduates to provide FP services without additional training. They felt that graduates lacked FP method-provision skills (especially IUD skills) and needed to develop these through inservice training programs.

In late 1995, JHPIEGO, the DPHC, NCK and DON met to discuss the resolution of these two competing perspectives and agreed that an assessment of the FP skills of graduating nursing students would be conducted to determine where the problems lay. During the nine months following the initial planning meeting in September 1995, a series of consensus-building meetings were held among the four organizations to:

- ◆ Determine how FP/RH training is conducted in the preservice and inservice systems
- ◆ Agree upon FP/RH competencies expected upon graduation
- ◆ Describe/develop consensus on what areas of FP inservice training could be subsumed in preservice education

In mid-1996, the DPHC, with team members from the DTCs, NCK and DON, supported by JHPIEGO, conducted a preservice nursing assessment at 12 nursing schools⁵ to evaluate FP

⁴ Providers who satisfactorily complete the IUD structured OJT course receive the same Ministry of Health certificate that graduates of the 6-week basic FP course receive.

⁵ These 12 schools cover the 2 cadres of nurses who make up more than 95% of nurses in Kenya.



knowledge and skills of nursing graduates and to determine their preparedness for FP-related job responsibilities (Brechin, Smith and Schaefer 1997). At each institution, the graduating class was assessed along with the tutors responsible for teaching FP. The clinical assessors were trainers from the key stakeholder institutions (NCK, DON, Medical Training Colleges [MTCs]⁶ and DPHC) who provided the team members with a real-world view of the effectiveness of preservice RH education. By the end of the assessment, all members of the assessment team, irrespective of institutional affiliation, were convinced of the urgent need to improve the quality of preservice FP/RH education.

Following the assessment, the DPHC realized that teaching basic RH skills like counseling and IP to large numbers of service providers during inservice training could not be sustained, and decided to reorient their strategy to ensure that all nursing students graduating from Kenya were competent in a basic set of FP/RH skills. The key institutions—the DON, the NCK and the MTCs—spearheaded by the DPHC and JHPIEGO, developed and implemented a strategy to strengthen the national training system that addressed the major issues in both preservice education and inservice training for nurses.

The Organizing Framework for This Report

This report is organized around the Monitoring and Evaluation (M&E) framework for JHPIEGO country training programs. Using the benchmarks that JHPIEGO/Kenya committed to achieve, it summarizes progress over the past four years. The report focuses on the establishment of an integrated RH clinical training network. Relevant achievements are discussed under the key indicators for M&E as well as within the relevant components for the indicators.

Since 1993, JHPIEGO has been able to track the majority of its activities through the use of its Automated Program Monitoring System (APMS[®]). In 1994, a detailed M&E framework was developed to provide both tracking and measurement of progress in global and country program activities reported to USAID at the Cooperative Agreement Indicator (CAI) level. The framework breaks down complex CAIs such as capacity-building activities into various benchmarks so that progress in achieving the CAIs can be monitored incrementally. For complex indicators (e.g., establishment of training programs), benchmarks are also categorized into components such as those that constitute training programs.

The M&E framework has four levels of achievement for benchmarks:

- Level 1:** Necessary first steps in a new training activity that are undertaken or, in a mature program, training activities that are revised/upgraded
- Level 2:** Achievements expected after a period of time (usually 2 to 3 years)
- Level 3:** The outcome expected after a minimum of 5 years of coordinated program efforts
- Level 4:** The ultimate goal—functioning in an organized fashion—within the individual component

Achieving benchmarks in levels 1 and 2 takes a period of intensive interventions supported by technical assistance to ensure that the foundation of the system has been strengthened by pulling

⁶ Medical Training Colleges are the nursing schools.

together the components of a training system. Achieving level 3 benchmarks signifies that interventions supported by technical assistance and policy/advocacy work have resulted in training systems elements in place and functioning at a basic level, and that capacity has been built up.

The key indicators defining the subsections of this report are:

- ◆ Country training sector assessed
- ◆ Joint national FP/RH training strategy developed and implemented
- ◆ National service delivery guidelines (SDG) developed/updated, adopted and disseminated
- ◆ Institutionalization of national SDG process (revision, updating and dissemination) for continuing change in medical and training policies
- ◆ Preservice/in-service FP/RH training program established
 - Reproductive health training program established in one or more of the major preservice (medical, midwifery, nursing) systems
 - In-service FP/RH training system (government or nongovernmental organization [NGO]) established
- ◆ Peri-program components (those training-related areas that are not tied directly to either preservice education or in-service training—but rather support both—and that link training to the service delivery system)

The last two indicators break down into components. These indicators are detailed further under the sections **Preservice/In-service Reproductive Health Training Program Established** and **Peri-Program Components**.

Programming for Results

When USAID/Washington instituted the orientation to results through its results-framework approach in both central and field programs a few years ago, JHPIEGO's M&E framework responded by linking to relevant USAID results. JHPIEGO's primary linkage has been to the Global/Population, Health and Nutrition Center's Strategic Objective (SO) 1, *Increased use by women and men of voluntary practices that contribute to reduced fertility*.⁷

⁷ Each Cooperative Agreement Indicator and benchmark are linked to one or more of the Intermediate Results (IRs) in SO 1 (mainly at the sub-result level) although most FP/RH country program activities contribute primarily to IR 3 and IR 4. The IRs are:

- IR 1.1 New and improved technologies and approaches for FP programs
- IR 1.2 Improved policy environment and increased global resources for FP programs
- IR 1.3 Enhanced capacity for national programs (public, private, NGO and community-based institutions) to design, implement, evaluate and finance sustainable FP/RH interventions
- IR 1.4 Increased access to, quality of, cost-effectiveness of and motivation for use of FP, breastfeeding and selected RH information and services.



For USAID/Kenya, JHPIEGO country programming responds to the Office of Population and Health SO *Reduce fertility and the risk of HIV/AIDS transmission through sustainable, integrated FP and health services through Intermediate Result (IR) 3, Increased customer use of integrated FP/HIV/AIDS/Child Survival (CS) services.* (See text box for a listing all 3 IRs.) Of the 5 sub-results (SR) for this IR, JHPIEGO/Kenya's program responds specifically to SR 3.3:⁸

SR 3.3 Key FP and HIV/AIDS service delivery support systems strengthened and institutionalized

**USAID/Kenya
Office of Population and Health
Results Framework**

SO: Reduce fertility and the risk of HIV/AIDS transmission through sustainable, integrated FP and health services

IR 1: Non-USAID financial resources for FP/HIV/AIDS/Child Survival (CS) increased

IR 2: Capacity of public and private health institutions to finance, plan and manage resources increased

IR 3: Increased customer use of integrated FP/HIV/AIDS/CS services

JHPIEGO/KENYA PROGRAM ACHIEVEMENTS

Country Training Sector Assessed

In mid-1994, JHPIEGO and its partners at the DPHC and the Department of Ob/Gyn (University of Nairobi) conducted a comprehensive assessment of the RH sector in Kenya (Weinstein 1995). This assessment was mandated in JHPIEGO's previous Cooperative Agreement and received USAID support and active encouragement. USAID facilitated JHPIEGO's collaboration with other partners in Kenya during this assessment for two reasons: to obtain a comprehensive picture of the RH training and service delivery system in the country and to ensure that the resulting recommendations would reflect the input of everyone involved. USAID was also supportive of this Reproductive Health Sector Assessment (RHSA) because it was proposed just prior to several major planning and policy-related activities on the part of the Ministry of Health (MOH) and USAID, including drafting the National Implementation Plan and conducting two planned FP study tours abroad.

Joint National Family Planning/Reproductive Health Training Strategy Developed and Implemented

Following the completion of the RHSA, JHPIEGO, the Department of Ob/Gyn and the DPHC used the Kenya RHSA as well as the *Evaluation of the Maternal, Child Health, and Family Planning Inservice Training Programme* to develop a country training strategy for Kenya:

Given the difficulties cited with the inservice training system: the system cannot effectively accommodate the training of large numbers; the staffing pattern of the DFH cannot monitor all the training activities; the DTCs are functional not structural centers; and the personnel deployment system does not support long-term assignments after training; alternative training

⁸ The remaining 4 SRs are: SR 3.1 Policies and program approaches for FP/HIV/AIDS/CS improved through research, analysis, M&E; SR 3.2 Improved prevention and management of childhood illnesses including malaria in a target district; SR 3.4 Integrated FP and HIV/AIDS services provided by selected NGOs and cooperating agencies; and SR 3.5 Increased availability of effective, gender sensitive, HIV/AIDS responses to selected populations.



approaches are needed to meet the projected needs for family planning service providers within a limited budget. Two alternative approaches include a review of the family planning training nurses receive during their preservice basic training (to identify whether they are competent to provide all nonclinical methods upon graduation); and the introduction of a system of 'on-the-job-training' (OJT) for specific methods, such as IUD and NORPLANT® implants (if approved for nurses) insertion and clinical skills such as infection prevention (Smith and Fenn 1995).

The training strategy made recommendations for clinical FP training for physicians, clinical officers and nurses, both inservice and preservice, but with a special focus on nurses who are the largest providers of FP services in Kenya. As a result of this strategic plan, JHPIEGO and the DPHC reassessed their working relationship and decided that innovative approaches would be needed to strengthen the FP training system with the limited funding available. A key success of implementing an integrated training strategy has been the consensus reached for annual planning meetings to review and revise the strategy, culminating in achievement of the level 4 benchmark for this indicator. (See Table 1.)

Table 1. Benchmarks of Progress for Joint National Family Planning/Reproductive Health Training Strategy Developed and Implemented

Level 1	Level 2	Level 3	Level 4
<ul style="list-style-type: none"> • <i>Host country officials sensitized to the need for an integrated approach to improving FP/RH service delivery</i> <ul style="list-style-type: none"> • <i>Service delivery guidelines (preservice and inservice)</i> • <i>Advisory group that comprises relevant stakeholders in the involved systems is formed</i> 	<ul style="list-style-type: none"> • <i>An integrated strategy based on needs assessment findings is designed/developed</i> 	<ul style="list-style-type: none"> • <i>Integrated strategy endorsed by policymakers and major stakeholder bodies represented in the advisory group (as formed in level 1)</i> • <i>Integrated strategy is introduced and disseminated</i> 	<ul style="list-style-type: none"> • <i>Mechanism for review and revision of the integrated strategy is in place (e.g., ongoing stakeholder meetings)</i>
<p>Benchmarks that have been achieved are shown in <i>italics</i>.</p>			



National Service Delivery Guidelines Developed/Updated, Adopted and Disseminated

Kenya's SDGs development work has reached level 3. (See **Table 2.**) In 1994–95, JHPIEGO assisted the DPHC and the Department of Ob/Gyn, University of Nairobi, to revise the national FP/RH SDGs to incorporate World Health Organization standards. All training curricula developed with JHPIEGO support were then harmonized with the SDGs. The SDGs were published in mid-1997 and disseminated at national meetings in 1997 and 1998. The guidelines have been printed with financial assistance from both JHPIEGO and the Department for International Development (DFID) to ensure enough copies for all service delivery points (SDPs) in Kenya. Although a national dissemination strategy has been discussed by the DPHC since 1997, until JHPIEGO received additional Maximizing Access and Quality funds from USAID/Washington in 1998, no donor had funding to conduct the district-level activities needed to update providers. To date, guidelines updates have been conducted during ongoing meetings for key administrators, educators and service providers. In 1999, district-level dissemination will begin.

Table 2. Benchmarks of Progress for National Service Delivery Guidelines Developed/Updated, Adopted and Disseminated

Level 1	Level 2	Level 3	Level 4
<ul style="list-style-type: none"> • <i>Host country officials sensitized about the need to strengthen the policy environment through revising SDGs/policy norms</i> • <i>FP/RH knowledge of host country officials updated</i> • <i>Consensus reached on the need for policy/service guidelines revision</i> 	<ul style="list-style-type: none"> • <i>RH Technical Advisory Group (RETAG or equivalent) formed to lead service guidelines revision process</i> • <i>Draft service guidelines document produced (by RETAG)</i> • <i>Medical barriers are addressed in national FP/RH guidelines</i> • <i>Service guidelines externally reviewed by e.g., key educators, providers and program managers</i> 	<ul style="list-style-type: none"> • <i>National service guidelines officially endorsed by national policymakers</i> • <i>National service guidelines document published and distributed</i> 	<ul style="list-style-type: none"> • <i>Dissemination strategy developed</i> • <i>System exists to institutionalize and standardize guidelines development, including regular revision and updating</i>
<p>Benchmarks that have been achieved are shown in <i>italics</i>.</p>			



Institutionalization of National Service Delivery Guidelines Process (Revision, Updating and Dissemination)

Institutionalization of the SDGs process—regular updating, continued dissemination of new information and assessment of service provider performance in accordance with the SDGs—has reached level 2. (See Table 3.) Although dissemination is just beginning to reach district levels, training materials have been harmonized and resource personnel have been trained.

Table 3. Benchmarks of Progress for Institutionalization of National Service Delivery Guidelines Process

Level 1	Level 2	Level 3	Level 4
<ul style="list-style-type: none"> • Availability of guidelines is systematically promoted • Implementation plan for dissemination strategy developed and approved 	<ul style="list-style-type: none"> • Core group of resource personnel are conducting technical updates based on new information in guidelines • Training and educational materials are harmonized and consistent with guidelines 	<ul style="list-style-type: none"> • Mechanisms in place that ensure that providers deliver services according to the guidelines 	<ul style="list-style-type: none"> • Ongoing quality assurance and supervision documents that service providers are still performing to the standards established in the guidelines
Benchmarks that have been achieved are shown in <i>italics</i> .			

In 1999 JHPIEGO, the DPHC and Family Health International (FHI) will conduct a collaborative project which will demonstrate the following:

- ◆ By using a decentralized training system, such as the DTC network in Kenya, contraceptive technology updates (CTUs) can be provided to large numbers of staff with minimum resources, even in remote areas.
- ◆ Through this system, relevant research results can be disseminated quickly and effectively to translate recent policy changes into action.

(The text box at right summarizes the research study. See **Appendix B** for further details about this research.)

Testing the Effect of Two Models for Providing CTUs

JHPIEGO, FHI and the DPHC will test two models of providing a CTU to determine the most effective approach to disseminating and operationalizing SDGs. JHPIEGO and FHI will randomly assign DTCs to a control or study group. FHI will evaluate the service delivery impact to assess whether one CTU strategy is more effective than the other. Evaluation indicators include changes in menstruation, age and parity requirements as well as changes in knowledge and attitudes of service providers by type of CTU model attended.

Preservice/Inservice Reproductive Health Training Program Established

The key components of the M&E framework for establishing preservice education and inservice training programs in a country's training system are:

- ◆ FP/RH Curricular Component/Course Schedule
- ◆ Staff/Faculty: Classroom Instruction
- ◆ Staff/Faculty: Clinical Practice
- ◆ Training Materials
- ◆ Clinical Training Sites
- ◆ Quality Monitoring System
- ◆ Training Information Systems
- ◆ Preservice/Inservice Program Advocacy^a

The first five components are closely related and synergistic. JHPIEGO programming assistance focuses on training-related interventions in these areas. The last three components—Quality Monitoring System, Training Information Systems and Preservice/Inservice Program Advocacy—require more than just targeted technical assistance and provision of materials for achieving progress. Therefore, interventions related to these areas usually follow achievement of benchmarks in the first five components (usually after achieving benchmark level 2 or greater in one or more components).

For the past two years, the focus of project activities in Kenya has been primarily on the development of the preservice nursing program. The progress made in achieving benchmarks under the components of the indicator, **Preservice/Inservice RH/Training Program Established**, thus far is summarized in **Table 4**, which shows a strong training systems foundation on which continued systems-strengthening is building.

^a This report focuses on preservice program advocacy.

Relevant progress and achievements of JHPIEGO's efforts under each component (individually or jointly) are discussed with emphasis on the benchmark level achieved. In addition, two special evaluation activities conducted in Kenya in 1996 and 1995, which reflect the overall achievement of interventions in several component areas, are discussed. The evaluation activity—*Family Planning/Reproductive Health Skills Assessment of Nurses Finishing Basic Training in 12 Institutions in Kenya*—is presented first because its results provided the basis on which the past three years of activities were focused.¹⁰

Table 4: Achievement of Benchmarks of Progress for Preservice Nursing Family Planning/Reproductive Health Training Program Established

Component	Level 1	Level 2	Level 3	Level 4
FP/RH Curricular Component/Course Schedule	/	/	FY01	
Staff/Faculty: Classroom Instruction	/	/	FY01	
Staff/Faculty: Clinical Practice	/	/	FY99	
Training Materials	/	/	/	FY01
Clinical Training Sites	/	/	FY99	
Quality Monitoring System	FY99	FY99	FY01	
Training Information Systems	/	/		
Preservice Program Advocacy	/	/		

Diagonal cross-hatching signifies achievement of benchmark(s) at that level. A blank cell means that—because of funding constraints—no further interventions are planned.

¹⁰ This assessment was conducted as a baseline evaluation because of the differing and competing perspectives between the inservice and preservice training wings in the MOH.



Evaluation: Family Planning/Reproductive Health Skills Assessment of Nurses Finishing Basic Training in 12 Institutions in Kenya

In mid-1996, the DON, NCK and DPHC, with JHPIEGO technical assistance, conducted an FP knowledge and clinical skills assessment of 2 cadres of nursing students (Kenya Registered Community Health Nurse [KRCHN] and Enrolled Community Health Nurse [ECHN]) just prior to graduation at 12 institutions to determine their preparedness for FP-related job responsibilities.¹¹ At each institution, the graduating class was selected for assessment along with the faculty responsible for teaching FP (Brechin, Smith and Schaefer 1997).

The assessment teams collected data through questionnaires (e.g., FP knowledge/attitudes, training experience and institutional) and through observation assessment of students in simulations of clinical skills (e.g., IP, method-specific FP counseling, FP-related gynecologic exam/IUD insertion). Teams of nurses from various nursing arenas (DTC and DPHC trainers, NCK and DON staff) assessed about 400 students and 25 tutors, and conducted interviews with faculty to determine the adequacy of available FP training materials.

In general, nursing student knowledge and attitudes were barely adequate for FP service provision. Student skill levels were even lower, in part because too many students were assigned to clinical practice settings (mean group size: 7 students). Only 65 students scored 80% or higher on the knowledge assessment. Although 89% of students performed the abdominal exam adequately, only 37% were competent in performing a bimanual exam. Almost no students were competent in performing the IUD insertion (10/119 or 8%), and only 2 tutors were competent in IUD insertion. In general, students treated FP counseling as history-taking and did not perform counseling well. Most of the students talked in a one-way monologue. Students' lack of knowledge and skills reflected lack of resources (e.g., anatomic models, training materials) and inconsistent exposure to updated practices across different clinical areas. In addition, many faculty had not been updated and had not been in clinical practice for many years. (See text box for a summary of selected key findings.)

Selected Key Findings from the FP/RH Skills Assessment of Nurses Finishing Basic Training in Kenya

- In spite of the graduation requirements set by the NCK, national nursing training requirements were not being met, in large part because of inadequate clinical practice to acquire skills.
- Inadequate caseloads for clinical FP methods and large numbers of students at a clinical site meant little actual hands-on practice for students.
- Responsibility for ensuring a student's clinical practice was not defined. Moreover, the lack of a "team" approach between the training institution and the clinical training site was a barrier to efficient clinical training.

¹¹ FP certification of registered nurse graduates was the key issue to be resolved. Traditionally, all FP service providers in Kenya were required to attend the 6-week basic FP skills course. Following the revision of the nursing curriculum, some of the material in this course became redundant for recent nursing school graduates. In particular, the NCK felt that knowledge and skills attained by KRCHN graduates were similar to those achieved by providers trained in the 6-week basic FP course given by the DPHC. Thus, the NCK felt that graduates should receive the same certificate that inservice providers received. Anecdotal evidence from inservice trainers presented another picture. They observed that nursing school graduates were not competent in basic FP skills and that they needed an additional "apprenticeship" before being allowed to deliver FP services, especially IUD skills.



Family Planning/Reproductive Health Curricular Component/Course Schedule

In 1991, the basic preservice curriculum for ECHN nurses had been revised with technical assistance from MEDEX to include FP skills, although the KRCHN curriculum had not been revised prior to 1996. The nursing assessment described above documented that the revised curriculum had not been implemented adequately and interviews with faculty corroborated this finding.¹²

In January 1997, a few months after the Nursing Assessment Dissemination meeting, JHPIEGO sponsored a workshop for DPHC and DTC trainers, MTC tutors, and NCK and DON staff. During the workshop, participants adapted training material from the 6-week basic FP course curriculum and developed a "self-paced learning" course for nursing students. JHPIEGO and the DPHC then developed a *National FP/RH Resource Manual* containing all the essential knowledge needed for either preservice education or inservice training in FP/RH, and a *Student Clinical Placement Guide (CPG)*, which was the accompanying self-paced learning package. Since September 1998, these materials have been implemented at the 15 pilot nursing school sites¹³ resulting in partial achievement of benchmark level 3. (See **Table 5.**) At the DPHC meeting on Preceptorship/OJT in 1998, representatives from NGO schools, who had been invited to participate in the meeting, asked to have the *National FP/RH Resource Manual* and *Student CPG*, even if they had to buy them.

Table 5. Benchmarks of Progress for Family Planning/Reproductive Health Curricular Component/Course Schedule

Level 1	Level 2	Level 3	Level 4
<ul style="list-style-type: none"> • <i>Adequacy of FP/RH curricular component/course schedule has been assessed</i> 	<ul style="list-style-type: none"> • <i>FP/RH curricular component/course schedule has been revised</i> 	<ul style="list-style-type: none"> • <i>Revised FP/RH curricular component/course schedule has been implemented in one or more institutions on at least a pilot basis</i> • Revised FP/RH curricular component/course schedule has been officially approved for use in all institutions 	<ul style="list-style-type: none"> • Revised FP/RH curricular component/course schedule is the official standard for training in all institutions
<p>Benchmarks that have been achieved are shown in <i>italics</i>.</p>			

¹² As one tutor reported to the assessment team, although the institution had been part of the original group working with the MEDEX Group to develop the curriculum, the faculty were never given technical assistance on how to implement the curriculum. They just received a set of binders for the classroom and clinical curricula.

¹³ Although 12 schools were assessed, JHPIEGO and DPHC agreed to add 2 schools that were not included in the assessment but were attached to one of the 12 DTCs, as well as the University of Nairobi School of Nursing's Bachelor of Science in Nursing program.



Staff/Faculty (Classroom Instruction/Clinical Practice)

In 1997 and 1998, JHPIEGO and the DPHC conducted a variety of training activities (IP, CTUs, counseling and clinical training skills) for DTC trainers, clinical preceptors and nursing school tutors.

The strategy for conducting these courses was to bring one DTC trainer (and sometimes one DTC trainer and one tutor) from each site to a central course, usually held in Nairobi. The DPHC and JHPIEGO staff or consultants were the lead trainers at each course. At the end of each course, DTC trainers scheduled dates for an "echo" training course to be held at the DTCs. The DTC trainer who attended the central course cotrained the echo course with assistance from one of the lead trainers from the DPHC or JHPIEGO. In this way, within a short period of time, hundreds of trainers and tutors were updated in selected clinical skills and clinical training skills. **Table 6** summarizes total participants trained under JHPIEGO/Kenya's achievements in the APHIA project.

Table 6: Participants Trained by Participant Type for Calendar Years 1995–1999

Participant Type	Training by Calendar Year				
	1995	1996	1997	1998	1999 (Qtr 1)
Service providers	270			12	
Trainers		10	139	46	7
Preceptors	200	6	584	122	95
Tutors			135	37	17
Other			9		105
TOTAL	470	16	867	217	224
Total trained 1995–1999: 1,794					

In May 1998, JHPIEGO and the DPHC staff conducted a 2-week Clinical Training Skills (CTS) course—the key course for imparting competency-based training skills—for one tutor and one trainer from each DTC/MTC site. The master trainers conducting this course found that the participants were comfortable giving illustrated lectures and working with audiovisual equipment, but some of them had never used a role play or a case study in a teaching situation. So, during the course, participants practiced role plays, case studies and other exercises found in the *Student CPG* and the *IUD Structured OJT Package* so that they could become comfortable with the variety of training methodologies. (See text box "CTS Course Focus" at right.)

CTS Course Focus

Many of the clinics where students and participants do their clinical practice have low FP-method caseload. Therefore, tutors and preceptors need to use a variety of teaching methodologies (especially role playing clinical situations) with students so that they can become competent.

The focus in the CTS courses was on practicing the role plays, case studies, demonstrations and coaching exercises until the trainers and tutors felt comfortable with them.

Subsequently, in July 1998, the DPHC, with assistance from JHPIEGO, launched the first of 13 workshops to improve the FP clinical training skills of tutors and clinical preceptors involved in



teaching nursing students. These CTS workshops were conducted by the core group of trainers and focused on providing tutors, trainers and preceptors with the skills necessary to teach the clinical component of either the preservice curriculum or inservice courses. The "echo" CTS workshops were conducted by a lead trainer from the DPHC with one tutor and one trainer from each DTC/MTC site. Generally, the cotrainers (from the MTC and DTC) had more difficulty understanding how to teach role plays and case studies and less trouble understanding the clinical coaching and demonstration skills.

During subsequent followup visits to assess the implementation of skills learned at the CTS workshops, the lead trainers who had taught the original CTS course found that participants who attended the CTS courses were still having problems understanding how to initiate the activities outlined in the preservice *Student CPG*. In response, JHPIEGO and the DPHC organized supervisory support team visits to each site to assist the tutors and trainers to implement the new preservice approach.¹⁴ Additionally, DTC trainers continue to cotrain the CTS course with a DPHC trainer until the DPHC trainer is confident that a DTC trainer is capable of conducting the training without additional technical assistance. Benchmark level 2 continues to be completed as the DTC trainers become able to conduct the CTS course independently. (See **Table 7**.)

Table 7. Benchmarks of Progress for Staff/Faculty (Classroom Instruction/Clinical Practice)

Level 1	Level 2	Level 3	Level 4
<ul style="list-style-type: none"> • <i>A core group of faculty/tutors in one or more institutions have been updated in their FP/RH knowledge</i> • <i>A core group of clinical trainers/preceptors involved in clinical practice have had their FP/RH skills standardized</i> 	<ul style="list-style-type: none"> • <i>A core group of faculty/tutors has been trained to transfer FP/RH knowledge effectively in one or more institutions</i> • <i>A core group of clinical trainers/preceptors involved in clinical practice has been trained to transfer FP/RH skills effectively in one or more institutions</i> 	<ul style="list-style-type: none"> • Trained faculty/tutors are successfully providing FP/RH instruction in one or more institutions • Trained clinical trainers/preceptors are successfully supervising FP/RH clinical practice in one or more institutions 	<ul style="list-style-type: none"> • Trained faculty/tutors are officially designated/responsible to teach the classroom portion of the FP/RH curricular component/course schedule in all institutions • Trained practitioners are officially designated/responsible as clinical trainers/preceptors for the clinical practice portion of the FP/RH curricular component/course schedule in all institutions
<p>Benchmarks that have been achieved are shown in <i>italics</i>.</p>			

¹⁴ The DPHC and DTC trainers help clinical preceptors focus on improving clinical, coaching and demonstration skills, and on strengthening preceptors' ability to conduct the role plays and case studies in the *Student CPG*.



Training Materials

To support the development of the trainer resources needed to implement the preservice nursing work at 15 schools, a resource package consisting of the *National FP/RH Resource Manual* and *Student CPGs*) was supplied to all institutions in the integrated training network. During ongoing supervision visits, DPHC and DTC trainers ensure that materials are in place and are being used correctly (benchmark level 3). (See **Table 8.**)

Table 8. Benchmarks of Progress for Training Materials

Level 1	Level 2	Level 3	Level 4
<ul style="list-style-type: none"> <i>The adequacy of the training materials/ supplies has been assessed in one or more institutions</i> 	<ul style="list-style-type: none"> <i>Adequate training materials have been developed for use in one or more institutions</i> 	<ul style="list-style-type: none"> <i>Adequate training materials/supplies are available in sufficient quantities to support ongoing FP/RH training in one or more institutions</i> 	<ul style="list-style-type: none"> A system exists for ensuring the provision of a sufficient number of (new/revised) training materials/ supplies to all institutions
<p>Benchmarks that have been achieved are shown in <i>italics</i>.</p>			

Clinical Training Sites

Following the 1996 preservice nursing assessment, the DTC trainers and nursing school tutors from the pilot schools conducted an assessment of the clinical sites that were then being used by either a nursing school or a DTC as an FP clinical placement. Trainers and tutors for each school had agreed to select 5 sites (health centers or hospitals) that would be used jointly by them for inservice and preservice clinical training. During the facility assessment, trainers and tutors examined variables such as FP method caseload, equipment and supplies needed for FP method provision, clinic space for counseling and exams, and proximity to housing for students. A facility assessment form completed by the assessment team for each clinical training site documented the baseline state of the facility prior to the start of the JHPIEGO/DPHC intervention.

As a result of the clinical training site assessment, JHPIEGO supplied anatomic models, resource materials and essential equipment to each of the 75 sites used in the integrated training network as well as to the DTCs and the nursing schools, resulting in achievement of benchmark level 2. (See Table 9.)

Table 9. Benchmarks of Progress for Clinical Training Sites

Level 1	Level 2	Level 3	Level 4
<ul style="list-style-type: none"> • <i>Service delivery sites affiliated with one or more institutions have been assessed for adequacy as clinical training sites</i> 	<ul style="list-style-type: none"> • <i>Services at sites affiliated with one or more training institutions have been strengthened (and/or the sites have been upgraded) to meet clinical training requirements</i> 	<ul style="list-style-type: none"> • Service sites affiliated with one or more institutions are functioning effectively (including being adequately equipped/supplied) as clinical training sites 	<ul style="list-style-type: none"> • A sufficient number of sites are functioning effectively as clinical training sites to meet clinic practice training needs in all institutions
<p>Benchmarks that have been achieved are shown in <i>italics</i>.</p>			



Quality Monitoring System

The quality monitoring system (QMS) for a training program is the program's internal quality control mechanism. It ensures that participants have the required skills at the end of the learning intervention. For JHPIEGO's preservice nursing intervention, the Kenya Medical Training Colleges have agreed that knowledge and skills competency must be demonstrated prior to graduation. Because the program is new, however, and a full year of teaching has not been completed, QMS benchmarks have not yet been achieved. (Level 1 will be achieved late in FY99.) **Table 10** outlines benchmark levels 1 through 4 for the QMS.

Table 10. Benchmarks of Progress for Quality Monitoring System

Level 1	Level 2	Level 3	Level 4
<ul style="list-style-type: none"> • Students/participants are tested in FP/RH topics as part of the classroom portion of the FP/RH curricular component/course • Skills assessments (on anatomic models and/or clients) are part of the clinical practice portion of the FP/RH curricular component/course 	<ul style="list-style-type: none"> • A passing score on a knowledge-based FP/RH test is required to pass the classroom portion of the FP/RH curricular component/course • Skills competency is required to pass the clinical practice portion of the FP/RH curricular component/course 	<ul style="list-style-type: none"> • FP/RH questions are included on the graduation exam (preservice only) • Some clinical FP/RH training is required for graduation (preservice only) 	<ul style="list-style-type: none"> • Demonstrated competency in FP/RH clinical skills is required (for a particular professional cadre) to be able to provide these FP/RH services upon graduation (preservice only)



Training Information Systems

One of the findings of the 1991 DFH/USAID training evaluation was that a lack of training and deployment information was seriously hindering the country's progress in FP service provision. An important part of JHPIEGO's planned assistance to developing an integrated training system was the establishment of a training information system (TIS) (Gaffikin, Brechin and McGrath 1998). Two key computer-based parts of the TIS, ProTrain[®] and TIMS^c (Training Information Monitoring System), were developed for use in Kenya. ProTrain is a training projection model for projecting needs for FP service providers. TIMS tracks health personnel receiving FP/RH training in various settings. After a national workshop on the role of a TIS (Gaffikin, Smith and Brechin 1996), a pilot test for a decentralized (district-level) TIS in Embu district was planned.¹⁵ From mid-1997 all TIS-related project activities were cut because of funding constraints; so, further efforts with ProTrain were curtailed.

In 1995, the DPHC and JHPIEGO developed criteria for participants of the 6-week basic FP course which have since been applied. And, over the past two years, JHPIEGO has continued to help institutionalize the use of TIMS (which has been adapted to meet a variety of training/tracking needs) to track training efforts by participant as well as by type of training event and to provide information for monitoring the national FP training program. As a result of these efforts, the Kenya program has achieved benchmark level 2. (See Table 11.)

Table 11. Benchmarks of Progress for Training Information Systems

Level 1	Level 2	Level 3	Level 4
<ul style="list-style-type: none"> Criteria are developed/ revised to select appropriate participants for specific FP/RH clinical training 	<ul style="list-style-type: none"> A TIS has been established at the national/regional/ institutional level to document the number of FP/RH professionals trained, by method and cadre 	<ul style="list-style-type: none"> The TIS links training statistics with service delivery information to enable service delivery gaps to be identified 	<ul style="list-style-type: none"> A mechanism exists for monitoring whether adequate numbers of providers are available/being trained for FP/RH service provision, by method and by cadre to meet ongoing/ changing service delivery needs
<p>Benchmarks that have been achieved are shown in <i>italics</i>.</p>			

¹⁵ The Embu District pilot test was for a system to "rationalize" trainee selection, to monitor adherence to selection criteria, to follow up trainees and to document post-training performance.



Preservice Program Advocacy

The process of designing and conducting the baseline preservice nursing assessment in 1996 actually resulted in a more constructive approach to preservice education by both inservice trainers and preservice tutors. The 1996 preservice nursing assessment was a collaborative effort among the funders of training, the trainers and the users of the training "product." This collaborative assessment resulted in the following seminal achievements:

- ◆ It created opportunities for all key stakeholders to work together and develop consensus on acceptable standards of performance and competence in FP/RH.
- ◆ It provided an opportunity to discuss problems encountered when implementing a training curriculum in a system where formal links between classroom and clinical training were few.
- ◆ It created a unified sense of purpose among the key stakeholders that resulted in a cooperative approach to reviewing and revising both preservice education and inservice training strategies for nurses in FP/RH.

For preservice training advocacy, benchmark level 2 has been achieved. (See **Table 12.**)

Table 12. Benchmarks of Progress for Preservice Program Advocacy

Level 1	Level 2	Level 3	Level 4
<ul style="list-style-type: none"> • <i>National level players sensitized to and achieved consensus on need for strengthening/developing (inservice) or strengthening/revising (preservice) training system</i> • <i>Advisory group formed to guide strengthening/developing (inservice) or strengthening/revising (preservice) training system</i> 	<ul style="list-style-type: none"> • <i>Program for strengthening/developing (inservice) or strengthening/revising (preservice) training system designed</i> • <i>Appropriate personnel implement program for strengthening/developing (inservice) or strengthening/revising (preservice) training system after orientation of all stakeholders</i> 	<ul style="list-style-type: none"> • <i>Program for strengthening/developing (inservice) or strengthening/revising (preservice) training system is regularly assessed and revised during implementation</i> 	<ul style="list-style-type: none"> • <i>Process for assessing and revising program for strengthening/developing (inservice) or strengthening/revising (preservice) training system has been institutionalized</i>
<p>Benchmarks that have been achieved are shown in <i>italics</i>.</p>			

Assessment team partners continue to present and use findings from the assessment to promote further strengthening of the preservice nursing education system among donors, the MOH and the nursing schools.

In defining the objectives for the assessment, the planning team also agreed that the results would provide guidance on how to revise inservice training to focus on skills that could not be acquired during basic training. This initiative led to the structured OJT pilot-test for IUD skills. (See **New Initiatives** in the next section for details.)



Peri-Program Components

Peri-program components include areas that are cross-cutting and affect both preservice education and inservice training programs.

- ◆ *New Initiatives*
- ◆ *Participant Selection Criteria*
- ◆ *Provider Supervision*
- ◆ *Qualification of Trainers/Trainer Development*
- ◆ *Licensure/Certification of Providers*
- ◆ *Provider Deployment/Job Assignment*

The last two components are less amenable to targeted interventions beyond benchmarks at levels 1 and 2. Because they are intersectoral by nature, these last two components require policy and advocacy work. They are not discussed further in this report.

New Initiatives

As described above, preservice program advocacy led to the identification of the need for alternative inservice training approaches. A structured OJT program¹⁶ for IUD insertion was proposed to resolve some of the criticisms of the NCK that KRCHN graduates were required to attend the 6-week basic FP course although they may have needed only refresher training in IUD insertion. In response, the DPHC, DON and NCK agreed that an IUD structured OJT program was an acceptable alternative to group-based IUD training. The representatives from these institutions as well as the DTCs constituted the "OJT Working Group."

In March 1996, JHPIEGO conducted a materials development workshop for DPHC, DON, and NCK staff and for several DTC trainers. During this workshop, materials designed by JHPIEGO for the same use in Zimbabwe (ZNFPC/JHPIEGO 1996) were tailored by the workshop participants to meet Kenya's needs. The workshop also focused on developing a system for supervision and certification of the OJT trainees. By the end of the workshop, participants agreed that graduates of the IUD structured OJT course would receive the same FP certificate that graduates of the 6-week basic FP course received as long as they passed the knowledge and skills assessments.

In July 1996, a training course was conducted for 6 OJT supervisors (DTC trainers) and 6 OJT trainers (clinical preceptors for the 6-week basic FP course who had previously attended an IUD standardization course). One DTC trainer (who attended as the OJT supervisor) and one preceptor (who attended as the OJT trainer) from 6 pilot institutions were selected to attend a course that emphasized clinical training skills in a one-on-one situation. Following the course, a pilot test of the IUD structured OJT program was initiated at the FP clinics at 6 provincial hospitals.

¹⁶ OJT (also referred to as site-based or clinic-based training) is a form of self-paced learning that allows the individual undergoing training to receive the necessary knowledge and skills in the job setting.



Following the course, a DPHC trainer visited each OJT site to assess how well clinical skills were being taught to the OJT trainees. The DPHC trainer who evaluated OJT trainers' skills remarked that the OJT trainers had better demonstration and coaching skills than other preceptors. During the final assessment of the IUD structured OJT pilot test (Brechtin et al 1999) in March 1998, the assessment team found that the OJT approach had been incorporated effectively into the existing service delivery system, and that OJT graduates appeared to have better IUD insertion/removal skills than participants of the 6-week basic FP course. (See **Appendix C** for a summary of this assessment.) This assessment resulted in partial achievement of benchmark level 3. (See **Table 13.**)

Table 13. Benchmarks of Progress for New Initiatives

Level 1	Level 2	Level 3	Level 4
<ul style="list-style-type: none"> • <i>Key stakeholders are sensitized to the need for the new initiative</i> • <i>Host country resources are educated about the new initiative</i> 	<ul style="list-style-type: none"> • <i>A strategy is designed for incorporation of the new initiative into existing programs</i> 	<ul style="list-style-type: none"> • <i>The new initiative is implemented on a pilot basis and assessed</i> • A strategy for expansion of the new initiative is developed 	<ul style="list-style-type: none"> • The new initiative is expanded into ongoing services
<p>Benchmarks that have been achieved are shown in <i>italics</i>.</p>			

One unexpected benefit from the IUD structured OJT program is that nursing officers have not redeployed OJT trainers outside of the FP clinic as they have redeployed other preceptors. Because OJT trainers are training hospital-based staff, not just nursing students or inservice participants for the 6-week basic FP course, hospital nursing officers, who normally redeploy nurses annually, have realized the professional benefit of keeping OJT trainers in the FP clinic.

Participant Selection Criteria¹⁷

Since 1995, JHPIEGO and the DPHC have been engaged in developing and enforcing minimum criteria for selection of trainers, preceptors and service providers for various training events. (Table 14 outlines the benchmarks for this process.)

Table 14. Benchmarks of Progress for Participant Selection Criteria

Level 1	Level 2	Level 3	Level 4
<ul style="list-style-type: none"> • <i>Selection criteria for participation in training system are identified and reviewed</i> 	<ul style="list-style-type: none"> • <i>Selection criteria revised so as to be supportive of quality training</i> 	<ul style="list-style-type: none"> • <i>Revised criteria adopted for use in training system and are disseminated</i> 	<ul style="list-style-type: none"> • Revised criteria implemented throughout the training system
<p>Benchmarks that have been achieved are shown in <i>italics</i>.</p>			

Selection of participants for training has often been irrational, ignoring selection criteria because:

- ◆ Selection of participants is often made by one individual (the nursing officer in charge of the ward or clinic).
- ◆ Funding for training comes from another sector (e.g., USAID or United Nations Population Fund [UNFPA]).
- ◆ Deployment of the trained providers is controlled by another person (usually the district public health nurse or the hospital nursing officer).
- ◆ Individuals who are not appropriate for FP courses may be chosen because they have not attended a workshop lately, or because the nursing officer may owe them a favor.

The DPHC established criteria for who was eligible to attend the 6-week basic FP course, but found it difficult to enforce because they were not notified ahead of time who would be attending. In contrast, when the IUD structured OJT course was developed, the OJT Working Group (DPHC, NCK and DON) established the criteria for the pilot test.¹⁸ These criteria were adhered to and the OJT program has had very few problems with inappropriate staff being trained.¹⁹

During the September 1998 Clinical Preceptorship/OJT meeting, participants from the range of training sections in the MOH discussed the problems of establishing and enforcing selection criteria. Selection criteria for trainers and preceptors were defined and are now being implemented in the integrated training network.

¹⁷ See previous section on *Training Information Systems* as well.

¹⁸ Only enrolled nurses who had graduated since 1992, registered community health nurses or nurses who had attended the 8-day FP course were eligible.

¹⁹ Key reasons are that no financial incentives are involved, and only motivated staff have been willing to work and study after they have completed their regular work each day.



Provider Supervision

In September 1998, a Clinical Preceptorship/OJT meeting was held. JHPIEGO invited a group of Kenyan nurses, including administrators, nursing school faculty and inservice trainers representing 20 nursing schools, 13 DTCs and 75 FP clinical training sites, to meet for 3 days to discuss basic training in FP for nursing students. A plan was to be developed to ensure that students would be competent in FP skills when they graduated (Ministry of Health 1998a). Although JHPIEGO and the DPHC have been working to reduce the need for inservice FP courses over the past 3 years, many barriers—including redeployment of skilled FP trainers and clinical preceptors to other clinical areas, poor trainer selection, lack of supervision of students, and weak linkages between hospitals and nursing schools—have delayed implementation of the new system. By the final day of the meeting, provincial and hospital nursing officers, district public health nurses, trainers and principal tutors had agreed to form a training advisory team at each of their sites. The advisory team would strive to improve trainer selection and deployment practices, improve student training and supervision, and strengthen communication between hospital administrators, nursing school faculty, clinical preceptors and inservice FP trainers. To follow up this meeting, JHPIEGO funded “echo” meetings for each of the DTCs to conduct a similar event. These meetings disseminated the results of the main preceptorship meeting with other key staff in their districts, including faculty from missionary nursing schools to develop a strategy that would meet their own local needs for preservice education and inservice training.

Benchmark level 2 has been achieved. (See **Table 15.**) DPHC trainers have begun making “supervisory team” visits to each of the DTC/MTC sites and their attached clinical training sites. The purpose of these visits is to ensure that trainers’ and preceptors’ clinical skills are standardized, that tutors and trainers are comfortable with coaching and providing skills demonstrations for students, and that materials are available in sufficient quantities.

Table 15. Benchmarks of Progress for Provider Supervision

Level 1	Level 2	Level 3	Level 4
<ul style="list-style-type: none"> • <i>Training officials and service delivery program managers have met to review and discuss how training meets service delivery needs</i> 	<ul style="list-style-type: none"> • <i>A strategy for orienting and/or training “supervisors” so that they can effectively monitor post-training skills application has been developed</i> 	<ul style="list-style-type: none"> • Orientation and/or training in clinical FP/RH skills has been initiated for existing “supervisors” who monitor post-training skills application 	<ul style="list-style-type: none"> • A system exists to ensure compatibility and continuity between initial followup of trained providers (by the training organization) and routine/regular supervision of providers
<p>Benchmarks that have been achieved are shown in <i>italics</i>.</p>			

Progress toward achieving levels 3 and 4 (**Table 15**) involves the establishment of linkages between inservice and preservice trainers to improve the quality of preservice FP nursing training. Although clinical staff are expected to help train nursing students, in most hospitals and health centers in Kenya, roles and responsibilities are unclear. For example, inservice trainers deployed in the clinical area recounted in the 1996 preservice nursing assessment that ECHN students were normally allowed to observe IUD procedures but not to practice, even though the NCK required that



students perform a certain number of procedures in order to graduate. Hospital nursing staff explained that they signed the student logbooks without verifying that the students had actually completed the procedures.

Following the nursing assessment, tutors, inservice trainers and staff from the DON and NCK agreed that clear guidelines would be developed for clinical preceptors, and that DTC trainers would also take a more active role in providing oversight and technical assistance for student training in the clinical area. All staff, including tutors, trainers and preceptors involved in either preservice or inservice FP training would be involved in team-building activities designed to promote standardized FP training. Tutors and trainers agreed that they would designate and use the same clinical training sites for all FP/RH training so that all training would be conducted at sites with adequate supplies of educational materials.

Since this strategy was agreed upon, JHPIEGO and the DPHC have conducted a series of training courses to strengthen the knowledge and skills of tutors, trainers and clinical preceptors, including IP and FP counseling workshops, CTUs and CTS courses. Several hundred tutors, trainers and preceptors have been trained to date in the same courses. Several preceptors have remarked during these courses that this is the first time they have ever attended a course with the nursing school faculty, even though they are all responsible for teaching the nursing students. In addition, a standardized workbook was developed by DPHC and DTC trainers, tutors, and the NCK and DON staff which will be used by both registered and enrolled nurse programs to train nursing students in FP.

Following the Clinical Preceptorship/OJT meeting, the participants made recommendations to improve the basic nurse training further by strengthening links between the hospital, the DTC and the MTCs. MTC tutors agreed to improve the provision of basic supplies to the hospital to compensate for use of equipment and commodities by students during training. They would do their best to ensure that tutors received more time to practice their clinical skills and to oversee students in the clinical area. Nursing officers in charge and district public health nurses agreed to modify current deployment practices that move trained clinical preceptors and trainers into clinical areas where they have no special expertise. Additionally, they agreed to ensure that the selection of preceptors and trainers would be based on the criteria agreed upon at this meeting. All participants felt that DTC trainers have a key role in both the inservice training and preservice education systems. DTC trainers are responsible for:

- ◆ Updating FP knowledge and skills of tutors, preceptors and other hospital staff
- ◆ Assisting tutors to present FP classroom lectures and demonstrations
- ◆ Providing support to clinical preceptors to ensure that students are getting adequate practice during their clinical placement
- ◆ Assessing FP skills for the students' final assessment
- ◆ Providing an important link between the MTC and the clinical area



Qualification of Trainers/Trainer Development

A key achievement in this component is that the DTCs are established as functioning training centers with the capacity to train (including management of training funds) in various RH areas (level 3—a core group of advanced trainers is functioning). In addition, a system exists for ensuring that all new clinical trainers are competent in FP/RH clinical skills and clinical training skills, and that existing FP/RH instructors receive teaching skills and FP/RH content updates (level 4). (See Table 16.)

Table 16. Benchmarks of Progress for Qualification of Trainers/Trainer Development

Level 1	Level 2	Level 3	Level 4
<ul style="list-style-type: none"> • A core group of clinical trainers have become advanced trainer candidates after completing the advanced training skills (ATS) course • A core group of proficient advanced trainers become master trainer candidates after at least one experience in adapting or designing a training course or event within one year of the ATS course 	<ul style="list-style-type: none"> • A core group of advanced trainer candidates have qualified to become advanced trainers after cotraining at least one training event, within a year after the ATS course, under the supervision of a qualified advanced or master trainer or technical expert • A core group of proficient master trainer candidates participate in at least one Training Needs Assessment and one Level 3 training evaluation within two years of the ATS course 	<ul style="list-style-type: none"> • A core group of skilled* advanced trainers is still functioning in this role (conducting CTS courses, adapting training materials and conducting needs assessments) one year after qualification (*"skilled" includes maintenance of routine service provision skills) • A core group of master trainer candidates becomes qualified as master trainers by submitting for review and approval applications/portfolios with supporting documentation to the JHPIEGO Trainer Review Group 	<ul style="list-style-type: none"> • A system exists for ensuring that all new clinical trainers are competent in both FP/RH clinical skills and clinical training skills • A system exists for ensuring that all new FP/RH instructors are competent in FP/RH classroom presentation skills • A system exists for ensuring that all existing clinical trainers receive FP/RH clinical skills and clinical training skills updates • A system exists for ensuring that all existing FP/RH instructors receive teaching skills and FP/RH content updates
<p>Benchmarks that have been achieved are shown in <i>italics</i>.</p>			

JHPIEGO began working with the DTCs in 1994 when the first CTS course was held for DTC coordinators. Following the CTS course, JHPIEGO began providing funds for the 6-week basic FP course and the 8-day dispensary-level course. Although the courses were conducted at the DTCs, DPHC trainers (from Nairobi) continued to provide the majority of the training, with limited assistance, particularly in logistics, from the DTC trainers.

Although funding for most of these courses for service providers was cut by JHPIEGO in 1996 and by UNFPA in 1997, JHPIEGO and the DPHC involved the DTC trainers in developing the strategy for strengthening preservice education. The initial phase of this strategy focused on updating and standardizing the knowledge and clinical skills of the DTC trainers, and then improving their training skills. When the DPHC and JHPIEGO staff first began updating the knowledge and skills of the DTC trainers during the IP, counseling and CTU courses, they were surprised to find that, although



the DTC trainers had been teaching the 6-week basic FP course for many years, many of them had difficulties during the basic skills courses (e.g., although they were **teaching** counseling, many of them were unable to counsel a client themselves). To remedy this situation, the DPHC and JHPIEGO agreed that a DTC trainer at each site would be selected to be the "expert" for a particular technical topic, and that this DTC trainer would be given additional cotraining opportunities with a DPHC trainer teaching this course. (See text box for an example of how DTC technical expert training is conducted.)

All level 4 benchmarks have been achieved through the decentralized focus on training courses. (See Table 16.) In late 1998, JHPIEGO asked nursing officers, DTC trainers, principal tutors and district public health nurses from each pilot site to develop a workplan of the courses they would like to conduct at each of their sites. With financial assistance from JHPIEGO and minimal technical assistance from the DPHC, DTC trainers have begun conducting IP, counseling, CTU and CTS workshops to expand the number of qualified clinical trainers available, and to train other tutors, trainers or service providers. Because many of the DTCs are now ready to organize and conduct courses²⁰ with minimal assistance, many more courses can be conducted in a short time. For example, during the month of March 1999, 24 courses are planned by DTCs around the country.

In addition, because DTCs are now able to conduct FP skills courses without technical assistance from the DPHC, they have begun holding 6-week basic FP courses on a cost-sharing basis. JHPIEGO has agreed to provide funds for materials, transport and lunches. Participants pay for their own lodging and other meals. During the first quarter of 1999, one 6-week course was conducted for less than US\$2,000 for 15 participants.²¹ Other DTCs have also requested funding to complement cost-sharing 6-week courses.

Evaluation: Assessing the Post-Training Family Planning Service Delivery Skills of Clinical Providers in Kenya

A study assessing the post-training FP service delivery skills of clinical providers in Kenya (see Appendix D) was carried out in 1995 to determine service provider competency (Valadez et al 1997). Results of evaluating FP/RH service delivery tasks revealed that the cohort observed one year after training exhibited about the same number of errors and task category-specific problems as the second cohort, observed just three months after training. Providers who were not currently providing FP/RH services had the most service delivery problems. These results suggest that skill

Development of DTC Trainers as Technical Experts: An Example

If a trainer conducts a course at a DTC, at least one other trainer from a different DTC also travels to the site to cotrain with the lead trainer. For instance, if the Embu DTC will be conducting a counseling training course, the "counseling" trainer for Embu (i.e., the trainer who attended the central course in Nairobi) will cotrain the course with the lead counseling skills trainer from the DPHC. Before the lead counseling skills trainer travels to Embu, s/he arranges to have a DTC trainer from another DTC (e.g., Nyeri) meet him/her in Embu. The Embu counseling trainer and the additional DTC trainer prepare with the lead counseling skills trainer, and then cotrain the course with him/her. Throughout the course, the lead counseling skills trainer coaches them to improve their training skills, corrects any technical errors and answers any questions they may have.

²⁰ Each course costs, on average, US\$1,000 per 1-week course for 15 to 20 people (not including technical assistance costs).

²¹ Formerly, the costs for 6-week courses averaged US\$30,000 for 15 participants (not including technical assistance costs).



retention is more dependent upon use of FP/RH skills by providers than upon the amount of time since training. This finding highlights the importance of assigning trained personnel to positions where they can continually use the skills in which they have been trained.

LESSONS LEARNED

Since 1996, the DPHC and JHPIEGO, with assistance from the DON and NCK, have greatly contributed to the way both preservice FP education and inservice FP training is conducted in Kenya. The training focus has gone from funding solely for group-based inservice training to a more balanced and sustainable approach that strengthens preservice education and provides IUD clinical and FP counseling skills as a certificate-level OJT course (equivalent to the 6-week basic FP course). Basic systems for national FP training have been established, and training costs per participant have been greatly reduced because training is now being conducted close to where participants live and work. In addition, although strengthening the DTCs was intended to improve FP training, one great benefit has been that a system was developed that can be used for training in other RH interventions—interventions for which training can be established much more quickly because the basic training systems elements are already in place.

Through close collaboration with the DPHC, DON and NCK, JHPIEGO has learned several important lessons about the ways to improve clinical FP training.

- ◆ **Strengthen preservice education appropriately and develop inservice training strategically.** JHPIEGO and the DPHC have worked with the NCK to establish more realistic guidelines about which clinical skills are appropriate for preservice nursing and which are not. “Rare-event” skills like IUD insertion are not appropriate for preservice nursing education because caseloads are inadequate for all nursing students to gain competency, and because—unless they are posted in an FP clinic—few service providers will have the opportunity to practice insertion skills often enough to maintain competency following graduation. In contrast, counseling and IP skills are used in every clinical area, and even nurses who are not immediately deployed to an FP clinic will have the opportunity to practice these skills.

JHPIEGO and the DPHC gained approval from the NCK to replace the requirement that IUD competency must be measured by insertion on a client. Competency on an anatomic model is now an appropriate measure for IUD insertion, and JHPIEGO and the DPHC are presently working to have the IUD competency requirement removed completely. Through use of the *Student CPG*, preservice institutions now focus on ensuring that students are competent in essential FP skills like IP, counseling, bimanual exam, and method provision for hormonal and barrier methods. To ensure that IUD services remain available, the IUD structured OJT course offers recent nurse graduates the chance to become proficient IUD providers through closely supervised but self-paced clinical practice, first with anatomic models and then with clients. This approach provides a model for other RH services. For example, if nurses are approved to perform MVA, postabortion care (PAC) counseling and IP can be strengthened in the preservice curriculum, and then complemented by a structured OJT MVA package to be offered to nurses working in the ob/gyn ward.



- ◆ **Establish an integrated clinical training system with sites that will be used for both inservice training and preservice education, and that have adequate clinical training materials, including anatomic models, reference materials and clinical equipment.** JHPIEGO and the DPHC have pioneered the development of an integrated clinical training system in which a limited number of clinical training sites are used for both preservice and inservice FP training. Designated sites have been supplied with adequate clinical training materials—including anatomic models, reference materials and clinical equipment—that can be used for both student and participant training. By developing a core group of trainers, tutors and preceptors, and by upgrading integrated clinical facilities, JHPIEGO and the DPHC have improved both training systems at a much lower cost than would have been the case if both systems were upgraded independently.

- Currently, more than 700 nursing students are sent to one of these 75 integrated clinical training sites for FP training.
- IUD structured OJT is presently conducted at 15 (soon to be 25) of these sites.
- Cost-sharing 6-week basic FP courses are planned for approximately half of these sites.

The integrated clinical training system has made quality assurance easier by reducing the number of training facilities to be supervised, and has helped the DPHC, MTCs and NCK focus on an issue previously overlooked—the state of clinical facilities used for training.

- ◆ **Develop appropriate materials to support training.** The development of a self-directed learning package for students has improved FP training for nurses without burdening nursing faculty with additional teaching. The *Student CPG* has helped nursing faculty provide structure to both the clinical and classroom FP experience. This guide has also helped MTCs and hospital staff resolve troublesome issues about who is responsible for ensuring that students are effectively trained in the clinical area. In addition, because the *National FP/RH Resource Manual* was developed from the 6-week basic FP course training material, it is cost-efficient and uses previously developed and approved content for both preservice education and inservice training. The *National FP/RH Resource Manual*—the first document in Kenya designed and used for both preservice education and inservice training—provides a model for how to make materials development more useful and cost-effective.
- ◆ **Ensure that trainers have standardized clinical skills, including IP, FP counseling and IUD insertion.** DPHC trainers visit all clinical sites to standardize the skills of the DTC trainers and clinical preceptors. During their visits, they also mentor the DTC trainers on how to conduct site-based clinical skills standardization. During this ongoing round of supervision visits, DPHC trainers focus on standardizing teaching as well as clinical skills.
- ◆ **Decentralize training expertise to regional and district training teams.** In the same way that JHPIEGO “mentored” DPHC trainers in technical and training skills, the DPHC is now working with DTC trainers to develop clinical expertise in the field. At each DTC, one trainer is selected to attend a central-level course in a specific technical area. Following the course, the DTC trainers then cotrain this course with a DPHC or JHPIEGO trainer. DPHC trainers continue to cotrain with the DTC trainers until they are proficient in both the technical content and training skills.
- ◆ **Provide nursing tutors, inservice trainers and clinical tutors with the same access to knowledge and skills.** At the 13 DTCs, courses in IP, FP counseling, contraceptive technology and clinical training skills have been provided for all staff or faculty involved in



training either nursing students or inservice participants. By using DPHC trainers to cotrain courses on-site with the DTC trainer from that site, per diem and travel costs have been minimized, and participation has been maximized. Ensuring that tutors, trainers and administrators all receive the same information reduces disagreements about appropriate clinical techniques and helps convince administrators to support training with hospital/clinic resources.

- ◆ **Monitor sites to assist clinical preceptors/service providers to establish and maintain high quality services that provide a model for students to follow when they graduate.** DPHC trainers regularly travel to each clinical site, with the DTC trainers who oversee those sites, to provide on-site assistance to the service providers and administrators. Gradually, the DPHC trainers are transferring these “technical assistance skills” to the DTC trainers who are responsible for ensuring that their training sites provide high quality services.
- ◆ **Establish a TIS that provides detailed information for central- and regional-level trainers on site and maintains information on trainer progress.** JHPIEGO has developed a computer-based TIS database that helps ensure the most capable trainer/tutor candidate is being trained at each site. Previously, the DPHC had problems with supervisors selecting participants for courses based on whose “turn” it was. Currently, JHPIEGO closely tracks information on trained DTC trainers, tutors and clinical preceptors. Included in the information system are noncourse data such as level of clinical skills at the last supervisory visit as well as data on trainers (e.g., which trainers have cotrained in which clinical skills). JHPIEGO is working with other CAs and the Division of Manpower and Planning (DMP) to institute a national TIS that will track training in all technical areas, and will provide the DMP with accurate, timely data on national training.
- ◆ **Create links between inservice trainers, preservice tutors, clinical preceptors and SDP administrators.** The DPHC and JHPIEGO are assisting the NCK and DON to establish a formal system of “preceptorship” that will ensure that clinical trainers, once trained, will only be deployed to health services where they will be able to use their clinical training skills. The DPHC and JHPIEGO are also promoting a system in which nursing tutors, DTC trainers and clinical preceptors meet regularly to discuss student scheduling in the clinical area, student progress toward training objectives and other clinical training needs. The NCK is proposing to adopt this system for all clinical teaching, using FP training as a model.
- ◆ **Ensure that inservice clinical skills training is provided in sustainable and appropriate ways.** The IUD structured OJT program, the first of its kind in Kenya, is making quality clinical training sustainable at the facility level. Prior to the development of the IUD structured OJT package, all service providers, whether they had adequate FP skills or not, were required to attend the 6-week basic FP course before providing FP services. The 15 hospitals/health centers where OJT has been started are now independent of the 6-week course for the production of qualified FP service providers. In addition, OJT course graduates have been found to have better clinical and counseling skills than their 6-week FP course counterparts because they continued to counsel women for IUDs as well as insert and remove IUDs long after their group-based colleagues were finished. Because of their familiarity with the structured OJT training package, graduates from the OJT program, with a little on-the-job help from DTC trainers, may go on to teach the OJT course themselves. Thus, structured OJT offers not only a sustainable approach to training service providers, it also offers the possibility of site-based sustainable training for clinical preceptors.



TRAINING DIRECTIONS

With USAID funding, the DPHC, DON, NCK and JHPIEGO have established the basic framework for a national integrated clinical training system. The system supports training and service delivery across various donor and CA-supported programs by:

- ◆ Strengthening IP practices and counseling
- ◆ Opening a dialogue with administrators and educators on inefficient deployment practices and selection criteria for clinical training sites
- ◆ Linking, and thereby strengthening, both inservice training and preservice education

Although the training system has been developed using an FP focus, other RH interventions can be quickly incorporated by building on cross-cutting skills, (e.g., IP and counseling) and by adding select technical components (e.g., MVA).

In Kenya, as many donors move to a district-level programming approach, national-level systems development, vital to developing technical and management capacity in the districts, is being neglected. For example, as donors such as UNFPA and DFID move support for RH away from developing a national FP/RH training system to working across all areas of RH service delivery in a few districts, certain key components necessary for district development are being neglected. Many donors assert in their district plans that specific RH training should be conducted in their selected districts, but do not state how the training will be conducted and who will do it.

Many of the recommendations in the National RH Training Plan address national issues that have an impact on service delivery, including deployment, selection criteria for sites and participants, and strengthening preservice RH education so that less inservice training is needed. Unfortunately, few donors have offered to assist the MOH in resolving these issues. (The text box summarizes the present RH training situation in Kenya.)

The Present RH Training Situation in Kenya

- There are 68 districts in Kenya.
- Each district has approximately 40 health institutions.
- Each institution needs from 1 to 4 service providers trained **annually** in each RH technical area.
- Each district needs service providers trained in FP, PAC, HIV/STI, safe motherhood, adolescent RH skills, RH cancer screening, infertility and gender sensitivity.

The current training situation in Kenya indicates that enormous numbers of **existing** service providers need to be trained in the next five years. The numbers do **not** include the 1,500 nursing students, 240 clinical officer students and 200 medical students who graduate annually. (These potential providers are not normally included in district plans because students come from districts all over Kenya and are often deployed outside of the district.)



RECOMMENDATIONS

◆ Strengthen national-level institutions to conduct district RH training.

Currently, JHPIEGO and the DPHC are working with 13 DTCs, the MTCs, NCK and DON to strengthen both preservice FP education and inservice FP training for nurses. Much progress has been made over the past four years in building a national training team among these institutions and in strengthening their technical capacity to develop curricula and conduct training for trainers and service providers. Despite this progress, their capacity to operate without funding and technical assistance is limited. (See text box for a list of key institutions.)

Strengthen Key National-Level Institutions

- DPHC
- DTCs
- MTCs
- NCK
- DON
- Department of Ob/Gyn (University of Nairobi)

JHPIEGO should continue to work with the pilot MTCs and DTCs to reinforce the gains made in establishing an integrated clinical training system. Specifically, JHPIEGO should continue to assist trainers and tutors to conduct clinical training jointly for trainers, tutors and service providers, to monitor clinical sites to ensure they are adequate for training, and to promote collaborative planning and evaluation of clinical training among faculty, trainers and service delivery staff. Trainers and tutors also need additional cotraining opportunities, as well as the chance to gain further supervision skills.

◆ Develop/adapt curricula for selected RH interventions.

USAID's influence and funding can ensure efficiencies of scale for training in selected RH interventions. Consideration should be given to forming a technical assistance "bank" for MOH units that are implementing RH interventions. This "bank" could coordinate support among the multiple donors and implementing agencies who assist the MOH to provide FP/RH training.

As donors expand from an FP to an RH focus, the national training institutions also need support to develop or adapt curricula for new technical areas. One concern with a district-focus program is that each donor or district will develop separate curricula that have no standardized format/methodology or no reference to the national clinical standards. USAID can influence the direction of the national RH training program by agreeing to coordinate and fund materials development for the major training institutions. (See text box for a summary of the recommendation to coordinate and fund materials development.)

Priority RH Interventions for Training Materials Development

- Safe motherhood
- PAC
- HIV/STI

USAID's influence through coordinating and funding materials development for the major training institutions will ensure standardization in RH training as well as use of appropriate service delivery practices.

This technical assistance "bank" for MOH units that need to develop materials would help ensure that materials are standardized and meet minimum quality requirements. Efficiencies of scale can be realized by



taking a modular approach to training curriculum development.²² Because key basic modules such as counseling and IP are already available for incorporating into new technical RH topics, materials would need only minimal adaptation for the technical area. A technical assistance bank would also ensure that trainers would always be able to train in a topic because the training “products” developed would be consistent.

In addition, the DPHC could coordinate RH materials development among the numerous donors and CAs. In this capacity, the DPHC could assist the MOH by establishing a “home” for all RH materials produced in Kenya and would further assist the MOH in the provision of FP/RH training. Currently, a wide variety of training materials are being used in Kenya; however, no one institution maintains an RH training materials library.

◆ **Work with the University of Nairobi Medical School, NCK, MTCs and DPHC to harmonize inservice and preservice curricula in all RH topics.**

As new RH courses/curricula are developed, implementors frequently forget to assist the preservice institutions to update their teaching materials. Currently, because no donor provides funds to enhance the preservice/in-service linkages, preservice teaching materials are often seriously out-of-date. JHPIEGO proposes that USAID provide funds to assist the preservice institutions to update and harmonize their teaching materials in the same RH areas that receive support through USAID inservice funds. These RH areas would include PAC, adolescent RH and voluntary surgical contraception. This USAID funding would also help standardize preservice RH education conducted throughout the country. Although medical and nursing schools usually have written curricula, they rarely have written teaching materials for each subject. Thus, what is taught to students at one school may be quite different from what is taught at another, depending on what the faculty member or tutor decides is important. (See text box for a summary of this recommendation.)

**Harmonization of
Inservice/Preservice Curricula**

USAID should lead Kenya donors in ensuring that funding for inservice RH training topics (e.g., PAC, adolescent RH, voluntary surgical contraception) also assists preservice institutions to update and harmonize their teaching materials.

◆ **Begin including other RH or CS interventions in DTC training.**

Currently, the DTCs provide training only in FP-related areas, including the 6-week FP course, the 8-day FP course, IP, counseling, CTUs and clinical training skills. When the DPHC has determined that the DTCs are ready to provide training in FP with no further technical assistance, USAID should assist the DPHC to introduce new RH technical areas into the DTC training mix, one technical area at a time. (See text box for a summary of this recommendation.)

Priority Training Interventions

The priority interventions for training should be:

- PAC
- Kenya Expanded Program of Immunizations (KEPI)
- Management of labor using the partogram

Build on FP-related interventions with trained service providers and provide funding for the DPHC to introduce new RH topics into courses offered by DTCs.

²² For instance, Kenya’s National AIDS/STDs Control Programme (NAS COP) has developed a distance learning package in STI treatment for physicians, but it is knowledge-based and has no clinical component. With minimal funding, USAID could provide technical assistance to NAS COP to help them refine their distance learning package and add a clinical component.



Some technical areas would need little additional work. For instance, PAC training is similar to FP training, except that PAC and FP counseling skills are somewhat different. DTC trainers already trained in FP counseling, IP and CTUs would need only a short practicum in counseling PAC patients. Then, having already acquired clinical training skills, these DTC trainers could begin conducting PAC training for service providers, tutors and others. This skill-building approach would be a very cost-effective way of expanding RH training.

◆ **Expand the preservice FP program from 15 pilot nursing schools to all schools in Kenya, and from FP alone to selected RH interventions.**

Currently, JHPIEGO works with 15 nursing schools, most of which are located near one of the 13 DTCs. Although Kenya has a total of 43 MTCs, these 15 schools account for approximately half of the nursing student population. Many of the remaining schools are nongovernmental.

During the preceptors' meeting in September 1998, representatives from the NGO schools as well as other government schools who attended the meeting, expressed a strong interest in participating in the program. Many of the NGO schools (mostly schools attached to missionary hospitals) have funds to purchase reference materials and models, but need technical assistance to conduct updates for their tutors and preceptors.

JHPIEGO proposes to use the DTCs to conduct on-site training for tutors and clinical preceptors from schools outside the pilot sites. Funds will be needed to provide transport and per diem for DTC trainers to visit the schools to conduct the training, and for an initial stock of reference materials and models for each school. By expanding the preservice program to all 43 nursing schools, USAID could ensure that the 1,500 nursing students who graduate annually would receive a standard package of FP information and skills.

In addition, as the system for conducting preservice clinical training is established, it would be relatively simple to introduce competency-based training in selected RH interventions into the curriculum. Using a modified self-paced learning approach similar to the *Student CPG*, it would be possible to expand preservice curriculum content without significantly increasing classroom hours. Although USAID has funded many innovative RH programs in Kenya, some of them—including adolescent RH and the COPE team-building model developed by AVSC International—have had limited impact because these approaches have been introduced at a relatively small number of SDPs. By introducing these interventions into both the medical and nursing preservice curricula, USAID could potentially have a much greater impact on services for the same cost. (See text box for a summary of this recommendation.)

**Preservice FP Program
Expansion**

Expand preservice FP nursing education to all nursing schools in Kenya.

As the preservice FP program is expanded, link each pilot site (DTC trainer and 1 tutor) to a sister nursing institution to ensure mentoring of the institution through the introduction process.

◆ **Expand the structured OJT approach (and similar self-paced approaches) to other clinical areas.**

USAID is currently the only donor in Kenya, through JHPIEGO and AVSC International, that has experience with structured on-the-job and site-based training materials. USAID could greatly influence the sustainability of RH training in Kenya by assisting the MOH to develop structured OJT packages for appropriate group-based courses. Now that a structured OJT approach has been developed and accepted by the MOH and NCK for FP, the approach should be expanded to other RH interventions. OJT is useful not only for training new service providers, but also for updating trained service providers or recent nurse graduates who have not been practicing their skills. OJT in selected RH interventions would enable districts to become self-sufficient in these skills by deploying providers trained under high-caseload conditions at the district hospital to initiate services at low-caseload health centers. (See text box for additional details.)

Conversion of Group-Based Training to Structured OJT

Support technical assistance for converting group-based training courses to structured OJT that will include the following interventions:

- KEPI
- PAC
- Management of labor including use of the partogram
- Logistics management

◆ **Using FP training as a model, catalyze the NCK's adoption of the formal system of "preceptorship" for all clinical teaching.**

All preservice clinical training, not just FP training, would benefit by providing qualified clinical preceptors to teach students. The NCK is interested in adopting this system nationally, but needs funds and technical assistance to do so. Now that FP preceptors have been established at the 15 MTCs and 75 clinical training sites, only minimal assistance will be needed to expand the system from FP clinics to other wards/units at these sites. These sites could then provide technical assistance to other training sites in nearby districts. (See text box for additional details.)

Preceptorship Advocacy

- Support district-level advocacy with district public health nurses and nursing officers in charge to introduce the preceptorship system.
- Work with the MOH DMP to establish criteria for clinical preceptors.

◆ **Assist the MOH to develop district training teams.**

Once the DTCs have been designated to provide clinical training without further DPHC assistance, DTCs could begin working with district-designated proficient service providers who could form the basis of a district training team (DTT). Each DTC could have certain districts assigned within their catchment area in which they would provide training and technical assistance. Because DTCs are located in only 13 of 69 districts, 56 districts are left with little training support.



The burden of working directly with 69 districts is overwhelming to the DPHC and other central-level RH technical units. To develop a sustainable national training program, some intermediary level technical assistance should be established between the national and the district levels. (See text box for a summary of this recommendation.)

District Training Teams

Use DTTs to meet inservice training needs and also to monitor and supervise preservice nursing education in their district.

- ◆ **Refocus MOH efforts on establishing a TIS that provides detailed information for central- and regional-level trainers for monitoring progress of the trainers and of the training sites.**

One of the findings of the 1991 DFH/USAID training evaluation was that a lack of training and deployment information was seriously hindering the country's progress in FP service provision. The government of Kenya and donors fund training without knowing how many service providers are needed or how many are available. Because multiple donors work across RH sectors, individual service providers are trained many times for different services, but are frequently deployed in a unit that provides none of those services. As the government expands to an RH approach, establishing a TIS that provides relevant training information on institutional district, provincial and national levels becomes even more crucial.

More importantly, a TIS helps build a national RH training network by focusing attention on selection, qualification and deployment of trainers and clinical preceptors. Currently, no standard criteria have been established to define who will be a trainer, what their skills should be before they are allowed to train providers and where they will be deployed to ensure maximum benefit for their district (as opposed to their institution). A TIS for all RH training would promote national dialogue on these issues and lead to a more efficient training system.

JHPIEGO is working with other CAs (particularly the Health Care Financing Project) and the DMP to institute a national TIS that will track training in all technical areas and provide the DMP with accurate, timely data on national training. Development of a computer-based TIS will also enable training data to be linked to other systems such as the DPHC contraceptive logistics management information system. Linking with this information system would enable measurement of the effect of training as it relates to contraceptive distribution at SDPs.

Additionally, computerization will facilitate the DPHC's ability to share training information with other training organizations (e.g., Christian Health Association of Kenya, Family Planning Association of Kenya, Family Planning Private Sector) so that duplication of training efforts will be minimized. Finally, through the development of compatible databases, the DPHC will be able to link with other MOH computer-based databases (e.g., personnel) so that deployment patterns and retention rates of trained providers can be assessed and monitored. (See text box for a summary of this recommendation.)

Develop a National TIS for All RH/CS Interventions

Refocus attention to a national TIS for all RH/CS interventions by standardizing course registration information and SDP coding, and assisting the MOH to develop a computerized TIS database.



◆ **Continue to strengthen the DPHC to assure advanced RH trainers.**

The DPHC continues to be a key player in developing RH training materials, standardizing skills of regional trainers, and establishing and overseeing quality assurance standards. To ensure that the DPHC continues to fulfill these roles, USAID should provide the DPHC with small amounts of funding and technical assistance. This funding could be used to send trainers on cotraining visits with master RH trainers, to sponsor DPHC trainers to become more experienced in instructional design, and to attend regional workshops for the development of SDGs, quality assurance techniques and other RH interventions. (See text box for a summary of this recommendation.)

**Quality Inputs Will Ensure
Quality Outputs**

- Assist development and implementation of a strategic plan for ensuring that all trainers keep current with their training skills.
- Provide more technical/ cotraining activities for DPHC trainers.

◆ **Pilot test information technology resources to ensure that preservice nursing institutions can stay current and keep their materials up-to-date and harmonized.**

USAID should fund JHPIEGO to establish technology-assisted learning centers (TALCs) in 3 of the preservice nursing institutions where the FP training program has been established. Many of the teaching problems encountered in the nursing schools would be ameliorated through use of computer-assisted learning programs. Many faculty lectures could be eliminated through computer-based courses, which would ensure that students throughout the country received standardized information. Computer-based courses would free faculty to spend more time on clinical demonstrations and supervision. In addition, exams could also be computer-based to assist tutors in calculating student results and to ensure that no student proceeded to the clinical areas without prerequisite knowledge. (See text box for a summary of this recommendation.)

**Establish Technology-Assisted
Learning Centers**

Establish pilot TALCs in 3 preservice nursing institutions.

SUMMARY

JHPIEGO, through the APHIA project, has made substantial gains in meeting sub-result 3.3, *Key FP and HIV/AIDS service delivery support systems strengthened and institutionalized*, in USAID/Kenya's Office of Population and Health Results Framework. The project has been successful in assisting the MOH to establish a national FP training system, which has now begun the project's consolidation phase with the key components of inservice training and preservice education programs for nurses in place and functioning at a basic level.

Training in both the inservice and preservice nursing wings has been linked at the clinical training site where economies of scale result from using one group of trainers for a variety of training needs. The key training institutions are defining the mix of skills appropriate for preservice nursing programs and determining which skills should continue to be met through inservice training. Training has been decentralized from the national-level DPHC to the DTCs so that more FP training



is conducted each year. Training costs for inservice FP courses have been reduced dramatically—and will continue to be reduced as the preservice nursing program is able to absorb more FP and RH interventions.

This consolidation phase is also the preparatory phase for moving next year into an expansion phase. This new phase will expand the preservice nursing program to cover the rest of Kenya's nursing schools and will move both inservice training and preservice education from an FP focus to an RH focus.

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APPENDIX A

Definitions Relevant to the JHPIEGO Trainer Development Pathway

Trainer Level	Definition
Clinical Trainer	A trainer who can impart clinical skills to providers. A clinical trainer must be proficient (expert) in the clinical FP/RH service for which s/he will be providing clinical training as well as competent in clinical training skills.
Advanced Trainer	A trainer who can impart clinical and clinical training skills to proficient service providers. S/he also should be knowledgeable and experienced in conducting various types of RH courses. Generally, a JHPIEGO advanced trainer first has been a proficient service provider, then a clinical trainer and has completed an apprenticeship (i.e., cotrained) with a master trainer as a part of a progressive experience in JHPIEGO training approaches.
Master Trainer	A trainer who can impart advanced and clinical training skills as well as clinical skills to other health professionals. S/he also should be knowledgeable and experienced in developing courses, conducting various types of training courses in RH and evaluating training. Generally, a master trainer first has been a proficient service provider and then a clinical trainer and an advanced trainer. The master trainer may assist with program development or program implementation or serve as a master trainer in a specific activity, including cotraining with a clinical trainer or an advanced trainer.
Classroom Faculty	A person who can impart knowledge to others, but who does not train others in clinical skills. These professionals usually function in preservice settings.
Clinical Instructor	A person who can transfer clinical skills to others, but is not qualified to impart knowledge to others (as a clinical trainer is). Clinical instructors are sometimes referred to as preceptors.
<p>Note: Trainers become <i>candidates</i> at a trainer level after finishing the required course work. They are then <i>qualified</i> once they complete the practicum/requirements specified for that trainer level.</p>	



APPENDIX B

Testing the Effect of Two Models for Providing Contraceptive Technology Updates

In 1999 JHPIEGO, the DPHC and FHI will conduct a collaborative project which will demonstrate the following:

- ◆ Using a decentralized training system, such as the DTC network in Kenya, the provision of CTUs to large numbers of staff with minimum resources is possible, even in remote areas.
- ◆ Through this system, the dissemination of relevant research results quickly and effectively is possible so that recent policy changes can be translated into action.

In addition, JHPIEGO, the DPHC and FHI will test two models of providing a CTU to determine the most effective approach to disseminating and operationalizing SDGs. JHPIEGO and FHI will randomly assign DTCs to either a control group or a study group prior to the beginning of the project.

JHPIEGO and the DPHC will conduct a “refresher” update for DTC trainers who had previously conducted the CTUs at their sites. For the first two days of the update, 2 DTC trainers from every site (a total of 26) will work with JHPIEGO and DPHC staff to practice teaching the CTU modules to each other. They will discuss logistical issues on how the district CTUs will be conducted, including the administration of a knowledge pretest that will be given to all participants. On day three, the trainers from the sites chosen for the control groups will leave the workshop and the DTC trainers from the study group sites will remain. During the final day, the remaining trainers will be trained in the use of the pregnancy identification checklist as well as on the use of an “orientation package.” This orientation package will be a short update (2 to 3 hours maximum) that providers who attend the district CTUs can use to update all staff from their sites. The package will focus on changes in the new SDGs and will address other key FP/RH issues.

FHI will evaluate the service delivery impact in both the control and study DTC groups to assess whether one CTU strategy is more effective than the other. Evaluation indicators include changes in menstrual, age and parity requirements. Indicators also include changes in knowledge and attitudes of service providers—including providers who attended the formal CTUs and providers who did not attend.



APPENDIX C

Summary of Key Findings from the Final Assessment of the IUD Structured On-the-Job Training Pilot Test (Kenya)

Following the course, a DPHC trainer visited each OJT site to assess how well clinical skills were being taught to the OJT trainees. The DPHC trainer who evaluated OJT trainers' skills remarked that they had better demonstration and coaching skills than other preceptors. During the final assessment of the IUD structured OJT pilot test in March 1998, the assessment team found that OJT had been well incorporated into the existing service delivery system, and that OJT trainees appeared to have better IUD insertion and removal skills than participants of the 6-week FP course.

Most of the trainees interviewed during the assessment (usually recently registered community nurse graduates) already had experience in IUD insertion prior to OJT, either in nursing school or in the MCH clinic. The assessment revealed, however, that the trainees still felt OJT was valuable because they learned more about genital tract infection screening, IP and the correct procedure for Copper-T insertion. Many trainees said that a big advantage of OJT was that their OJT trainers knew them very well, so the trainees felt very comfortable asking questions and even making mistakes. Trainees said their trainer knew exactly how well they performed, and would not let them proceed to a client until they were proficient on the anatomic model. Trainees liked having their trainers available, even after the OJT course was finished, for consultation and advice on how to handle complicated cases.

The DTC trainers interviewed during the assessment said that OJT-trained staff had better IUD insertion skills than participants in the 6-week course because they had one-on-one training, sufficient time to practice on the pelvic model and as much time as they needed to gain proficiency with clients. The trainers also said that the OJT-trained staff were better FP counselors because they have had much more practice counseling all types of clients. During the 6-week course, the participants need to meet their IUD insertion "quota"; so they spend much of their time "motivating" clients to accept an IUD. The OJT-trained knew that they were not time-limited; so they said "we follow the client's choice" and gave the clients the method they wanted.

The DPHC and JHPIEGO have found that OJT-trained FP staff seem to have better coaching and demonstration skills than providers trained in a group-based course. Because they spend so much time reading and practicing from their workbook and reference manual, OJT trainees leave the OJT course almost prepared to teach OJT themselves. One OJT trainee from Embu was transferred to a health center where she is now conducting OJT herself, after having an "on-the-job" update in training skills from the OJT supervisor. OJT provides a low-cost and sustainable mechanism for ensuring a steady supply of preceptors as well as service providers.

One unexpected benefit from the IUD structured OJT program is that nursing officers have not redeployed OJT trainers outside of the FP clinic as they have redeployed other preceptors. Because OJT trainers are training hospital-based staff, not just nursing students or inservice participants for the 6-week course, hospital nursing officers, who normally redeploy nurses annually, see the professional benefit of keeping the OJT trainers in the FP clinic.



APPENDIX D

Executive Summary of Assessing the Post-Training Family Planning Service Delivery Skills of Clinical Providers in Kenya

This assessment (Valadez et al 1997) established the link between service quality and initial training by examining the skill retention of 2 cohorts of service providers who participated in an FP training program in Kenya during 1994–1995. The following two questions were considered: 1) Do providers use the skills in which they were trained? 2) Is the length of time after the course concludes related to whether trained providers retain their new skills?

In May and June 1995, 6 *observers* (nurse/midwives whose skills were standardized) collected data to evaluate the 2 cohorts mentioned above. (A total of 30 nurses and midwives were evaluated.) Although both cohorts had received identical training, they differed in time elapsed since training (i.e., 1 year versus 3 months). Results of the evaluation of 101 FP/RH service delivery tasks revealed that the cohort observed one year after training exhibited about the same number of errors and task category-specific problems as the other cohort observed just three months after training. Most service delivery problems were attributed to providers who were not currently providing FP/RH services—which suggests that skill retention is more dependent upon use of FP/RH skills by providers than upon the amount of time since training. This finding highlights the importance of assigning trained personnel to positions where they can continually use the skills in which they have been trained. Study results also identified areas of training needing emphasis or improvement and revealed that counseling, in particular, needs improvement.

For the first time, the Lot Quality Assurance Sampling (LQAS)—a rapid sampling method that has been used several times to assess CS, and Maternal and Child Health interventions—was adapted to assess the quality of FP service provision. This current study field tested LQAS as a tool that could enable a supervisor to identify barriers to service quality. LQAS was used to measure the quality of the service delivery environment and the FP skill retention of the 2 cohorts of service providers described above.

In addition to assessing cohorts of providers, LQAS was useful in assessing an individual provider's specific service delivery skills and could, potentially, be used for supervision. LQAS results could enable a clinical supervisor to take corrective action at the facility immediately after the skill retention judgment was made. And by using this methodology with a simple paper and pencil or computerized database, a manager or supervisor could track skills performance of several providers over time. These data could then be used to schedule supervisory visits, refresher courses, OJT and basic clinical courses.

Furthermore, LQAS results collected over time could be incorporated into a management information system, such as Kenya's DFH TIS, to provide decision-makers with important information about service quality on a site-by-site or area-by-area basis. The TIS, using LQAS data, could then assist managers to allocate newly trained providers to vacancies at facilities most in need, and also help them set priorities for new FP/RH training.

